

Home Visits

Home Visits are conducted to outreach, engage, assesses, support, and educate and coach patients. Home Visits will be coordinated based on need to ensure that appropriate support is provide to patients identified as “at-risk”.

PROCEDURE

1. **A Care Team Member will:**
 - a. Determine the need for a home visit based on:
 - 1) Patients' eligibility for service.
 - 2) Need for home visit outreach to engage or re-engage patient in care or to address biopsychosocial condition requiring home visit intervention.
2. **Referral criteria include, but are not limited to, the following:**
 - a. Diagnoses and utilization patterns that result in patients being considered at-risk. Since these diagnoses may evolve overtime particular details will not be provided
3. **The Care Team Member will:**
 - a. Contact the patient to schedule the visit.
 - b. Notify supervisor when leaving and of expected return time.
 - c. Utilize electronic tracking device to promote safety and accountability (Safe Signal).
 - d. Document outcome of home visit in the electronic medical record and/or care management platform including actions taken and referrals if made.
 - e. Follow up as needed with patient and care team regarding outcome of visit/intervention.
 - f. If concern about safety is present, staff member may be accompanied by a second staff member during the visit.